FILED APR 15 1940

V. S. No. 2
DM—11-10-39
ev. 5-17-39
1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9511

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2994

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2617 Madison St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 60 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County

(c) City or town St. Louis.
(If outside city or town limits write "RURAL")

(d) Street No. 2617 Madison St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME John W. Quest.

3. (b) If veteran, name war No. 3. (c) Social Security No. None.

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anne Quest 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased April 8 1850
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 22 If less than one day hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country)

10. Usual occupation None.

11. Industry or business

MOTHER FATHER

12. Name Unknown.

13. Birthplace Germany. (City, town, or county) (State or foreign country)

14. Maiden name Unknown.

15. Birthplace Unknown. (City, town, or county) (State or foreign country)

16. (a) Informant Anna Quest
(b) Address 2617 Madison St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-40. (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cem.

18. (a) Signature of funeral director Hy. Leidner Undco
(b) Address 1417N. Market St.

19. (a) MAR 31 1940 (Date received local registrar) (b) J. F. Gudeth (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 30
year 40 hour 10 minute A M.

21. I hereby certify that I attended the deceased from Jan 1939, 19, to 3 30 19 40
that I last saw h alive on 3 30 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hy Bronchialis Pneumonia	
Due to Bronchitis	3 4 days
Due to La Grippe	2 wks
Senility	1 yr
Due to	
Other conditions (Include pregnancy within 3 months of death) Mitral Regurgitation	1 yr

PHYSICIAN

Major findings:
Of operations
Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address 1875 Madison Date signed 3 31 40

(Licensed Embalmer's Statement on Reverse Side)

OCT 26 1943

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.